

Home Care Intake Form

Member Name: _____ Member ID#: _____

Date of Birth: _____ Husky: _____ Charter Oak: _____

Contact Name: _____ Home Care Agency: _____

Contact Ph #: _____ Contact Fax #: _____
(If different from caller)

Date of initial visit: _____ Diagnosis/code: _____

Services requested: _____ Frequency/Duration/Date Range: _____

Skilled Nursing _____ (visits/wk)

Home Health Aide _____ (hrs/day/wk)

OT _____ (vts/wk) PT _____ (vts/wk)

ST _____ (vts/wk)

Date of MD f/u: _____

Wound Care: Size of wound: Width: _____ Depth: _____ Length: _____

Treatment requested: _____

Please provide updated clinical with faxed request
Clinical notes including 485 form must accompany fax request.

Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST****
